PRINTED: 06/24/2014 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		157596	B. WING		0.0	C <b>06/03/2014</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311		5/03/2014	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 000	INITIAL COMMENTS		G 0	00			
	This was a home hecomplaint investigation						
	•	328 and IN00148240 - ral deficiencies related to the					
	Survey Date: May 28	3 - June 3, 2014					
	Facility #: 007377						
	Medicaid #: 2008732	50					
	Surveyors: Ingrid Mil Public Health	ler, MS, BSN, RN n Nurse Surveyor					
	providing its own hon competency evaluation years beginning June due to being found of Conditions of Particip Rights; 484.18 Accept Care, and Medical Su						
	The Administrator info preclusion on June 2	ormed of the above-stated 2014, at 11:40 AM.					
	Quality Review: Joyc June 13, 20	e Elder, MSN, BSN, RN 14					
G 100	484.10 PATIENT RIG		G 1	00			
	This CONDITION is	not met as evidenced by:					
ARODATORY	NIDECTOR'S OR PROVIDER!	SLIPPLIER REPRESENTATIVE'S SIGNATUR		TITI F		(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 007377

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		157596	B. WING		C 06/03/2014
	ROVIDER OR SUPPLIER	;		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311	1 00/03/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
G 100	review, agency docur was determined the acompliance with this of the patient's right to of 12 records reviewed all 72 patients of the to follow their own poland document the excomplaint for 1 of 1 apotential to affect all agency (see G 107); was informed in advacare to be furnished in with the potential to apatients (see G 108); patient's right to confiniformation had been shared her password information with anotic creating the potential 72 current patients (see The cumulative effect resulted in the agency compliance with the CCFR 484.10 Patient F 484.10 PATIENT RIGOTH The patient has the rights. The HHA in the exercise of those This STANDARD is a Based on interviews records, and agency	cord and agency policy ment review, and interview, it agency failed to maintain condition by failing to ensure dignity was maintained for 3 and with the potential to affect agency (see G 101); failing office to investigate complaints istence and resolution of the gency reviewed with the pof the patients served by the failing to ensure the patient ance of any changes in the in 3 of 12 records reviewed affect all the agency's and failing to to ensure the idential clinical record in protected when employee I to access clinical ther person for 1 of 1 agency to affect all of the agency's see G 111).  It of these systemic problems by being found out of Condition of Participation 42 Rights.  SHTS  Sight to be informed of his or must protect and promote	G 10		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		157596	B. WING _			C 06/03/2014	
	PROVIDER OR SUPPLIER	С		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311	•	00/03/2014	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 101	Findings  1. The agency docu Rights and Responsistated, "The patient or her rights as a pa agency as follows: the informed about the follows the patient verbal, physical, and be treated with dignitive that and Responsibilities  2. The agency admundated document that and Responsibilities  3. On 6/2/14 at 3:45 having a complaint of (HHA). The HHA has bath or having the bhaving both tasks docertification period 4 anything the aide was the HHA, Employee The patient had complaint log.  A review of clinitipatient had signed the care on 4/5/14.	fied in the agency's "Patient's asponsibilities" for 3 of 12 atient #20, #21, #22).  Imment titled "Patient Bill of ibilities" with no effective date has the right to exercise his tient of the home health the patient has the right to be care to be furnished, and the care to be furnished as the has the right to be free from a psychological abuse and to ty."  It ission package contained an itted "Patient Bill of Rights	G 1	01			

PRINTED: 06/24/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		157596	B. WING				02/2044
	ROVIDER OR SUPPLIER  OME HEALTHCARE INC	l	1 2	S 4	TREET ADDRESS, CITY, STATE, ZIP CODE  25 S JOLIET ST STE 312  DYER, IN 46311	06/	03/2014
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 101	from the home health to evidence the agend that they were to receipation had been disconnected as a review of clinic patient had signed the second condicated Employee Twant [patient #22] to get to put [patient #22] in shower [the patient] was A review of clinic	she was receiving services agency. The record failed by had infomred patient #21 eive services or that the sharged.  al record #21 indicated the e patient rights on 10/3/13.  AM, patient #22's caregiver T, HHA, had stated, "If you get a shower, you will have there yourself and then I will	G	101			
G 107	and Responsibilities" stated, "The patient h or her rights as a pati agency as follows: the informed about the of any changes in the follows the patient verbal, physical, and be treated with dignity 484.10(b)(5) EXERCI RESPECT FOR PROTECT The HHA must invest patient or the patient's regarding treatment of furnished, or regarding patient's property by	SE OF RIGHTS AND P igate complaints made by a	G	107			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		157596	B. WING _			C 06/03/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311	1	7575572014	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
G 107	of the complaint.  This STANDARD is Based on policy reviadministrative documenthe agency failed to finvestigate complaint existence and resolute 12 records reviewed all of the patients sere 19, 20, and 22)  Findings include  1. The agency policy and Responsibilities stated, "The patient for her rights as a patient of the patient with the detreatment or care fur agency to voice constants.	not met as evidenced by: ew, clinical record review, nent review, and interview, follow their own policy to its and document the tion of the complaint for 5 of l with the potential to affect ved by the agency. (#12, 14,  // titled "Patient Bill of Rights with no effective date has the right to exercise his ient of the home health of the home health agency as has the right to place a epartment regarding hished by a home health omplaints about care or inization investigates the	G 1				
	undated document tirand Responsibilities.  3. Clinical record #12 evidenced the patien rights at the start of complaint documente	2, start of care 10/23/13, t had received the patient care and failed to have a ed, investigated, or resolved.					
	The complaint log fai complaint.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		157596	B. WING		C 06/03/2014	
	NAME OF PROVIDER OR SUPPLIER  INCARE HOME HEALTHCARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311	00/03/2014	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
G 107	having a complaint to by the administrator of not receiving aide of care.  4. Clinical record # evidenced the patient rights at the start of complaint document. The complaint log facomplaint.  a. On 5/28/14 at that nursing services notice. Patient #14 with the office person Employee A, the administration in the complaint occurred despite parcalls to the office and that the patient need Employee A. At one call on speaker phone Employee A talking a patient #14 and compatient #14 and compatient #14 and compatient #14 and compatient #15 and never did invest complaint. Patient # supplies for an abdonot receive any more agency staff stopped discussing this failur Patient #14 indicate.	23 PM, the patient indicated hat had not been addressed. The patient had complained visits as ordered on the plan  14, start of care 8/12/13, and the received the patient care and failed to have a red, investigated, or resolved. A resolved without any indicated filing a complaint neel and requested that ministrator and director of the complaint. This never tient #14's numerous phone do being told that the person red to speak to was recall, the office staff put the recall and patient #14 could hear about not having time to call aplaining that the patient remaining that the patient resolved to speak to was recall, the office staff put the recall and patient #14 could hear about not having time to call aplaining that the patient remaining that the patient resolve the patient's resolve the supplies when the do visits without notice or reto visit with her / him.	G 10'	7		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157596			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		157596	B. WING		C 06/03/2014		
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311		00/03/2014	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 107	Registered Nurse in not been filed in the 5. Clinical record #19 received the patient had not had a complinvestigated, or reso failed to evidence the On 6/2/14 at 2:1 complained that the and canceled and ha occur that weekend. patient indicated call complaining and that 6. On 6/2/14 at 3:45 having a complaint w (HHA). The HHA ha bath or having the behaving both tasks do had only visited twice complained to the of asked to not have the had not been docum.  A review of clinic patient had signed the care on 4/5/14.  7. Clinical record #22 evidenced the patient rights at the start of complaint document. The complaint log fa complaint.	c. 10:25 AM, Employee C, dicated the complaint had complaint log.  D, start of care 4/5/2014, had rights at the start of care and aint documented, leved. The complaint log e complaint  O PM, patient #19 physical therapist had called a said that a visit would  No visit had occurred. The ing the office and a no follow- up had occurred.  PM, patient #20 indicated with a home health aide a digiven him / her a choice of ed made and not a choice of ed made and not a choice of each made and read and each each enter the complaint log.  Cal record #20 evidenced the ne patient rights at the start of each investigated, or resolved.	G 1	07			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		С	
		157596	B. WING			06/	03/2014
	ROVIDER OR SUPPLIER  OME HEALTHCARE INC			42	TREET ADDRESS, CITY, STATE, ZIP CODE 25 S JOLIET ST STE 312 YER, IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 107	indicated calling Empthat the patient was renot showers that had indicated receiving not complaint. In Februa also complaint. In Februa also complained and plan of care was alter that he /she should be follow up with this con attorney indicated last administrator about the showers as requested.  8. A review of the conevidence any investiged documentation concepatient #12, #14, #19 484.10(c)(1) RIGHT THARTICIPATE  The patient has the riadvance about the cast any changes in the cast the disciplines that wis frequency of visits profit the HHA must advised the the disciplines that wis frequency of visits profit the HHA must advised any change in the platis made.  This STANDARD is real that wis review, interview, and review, interview, and review, interview, and review, and review, interview, and review in the review in the platic made.	mal caregiver of patient #22 bloyee A with a complaint ecciving sponge baths and been agreed upon. He/she of follow up with his ry, the power of attorney had requested that any time the red or days were changed e contacted. There was no implaint. The power of t week to talk to the ne patient not receiving d and getting no response.  Implaint log failed to ration or other rining the complaint filed by the patient of the patie		107			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		157596	B. WING _		C 00/02/2014		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 425 S JOLIET ST STE 312 DYER, IN 46311		06/03/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 108	Continued From page	e 8	G 1	08			
	in advance of any changes in the care to be furnished in 3 of 12 records reviewed (#14, #21, #22).  Findings include  1. The agency policy titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "The home health agency must protect and promote the exercise of these rights as follows the patient has the right to exercise his or her rights as a patient of the home health agency as follows the patient has the right to be informed about the care to be furnished and of changes in the care to be furnished the home health agency shall advise the patient in advance of disciplines that will furnish care, and the frequency of visits proposed to be furnished the home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice."						
		ssion package contained a n cled "Patient Bill of Rights"					
	evidenced the patien rights at the start of c	4, start of care 8/12/13, t had received the patient care and was not aware of cices that occurred in March					
	that nursing services notice in early March filing a complaint with requested that Emplo	7 PM, patient #14 indicated were stopped without any 2014. Patient #14 indicated in the office personnel and byee A, the administrator and evestigate the complaint. despite patient #14's					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED	
		157596	B. WING		C 06/03/2014	
	ROVIDER OR SUPPLIER	;		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311	00/03/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION	
G 108	that the person that to was Employee A. put the call on speak could hear Employee time to call patient # patient called several indicated on the special when the meeting that time she would return a call and never the patient's complaineding supplies for dressing and did not supplies when the accomplaineding supplies for dressing and did not supplies when the accomplained hemodialysis and agency.  b. On 5/29/14 at Registered Nurse (Ronot informed of the decomplained of the decomplained in the home health age not being aware of both of care dated 02-01-orders for the aide to living and personal content of the decomplained in the patient of the	Is to the office and being told he patient needed to speak At one call, the office staff er phone and patient #14 At a Atalking about not having 14 and complaining that the I times. Employee A aker phone her intentions to goccurring was done and at return call, but she never dider did investigate or resolvent. Patient #14 indicated an abdominal fistula receive any more of these gency staff stopped visits cussing this failure to visit at the start of care with the 10:25 AM, Employee C, N), indicated the patient was ischarge.  AM, patient #21 indicated ewas receiving services from ancy. Patient #21 indicated en glischarged. The plan 14 to 04-01-14 evidenced assist with activities of daily are and hygiene. All the aide to recent one dated 3/25/14.) as to have a tub or shower ed to evidence a subsequent	G 10	08		
		signed the patient rights on				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION  NG	(>	(X3) DATE SURVEY COMPLETED  C 06/03/2014	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311		06/03/2014
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G 108	b. On 6/3/14 at indicated that patient baths because insteathe same household, was done for convenions.  5. On 6/3/14 at 10:25 indicated that patient patients #21 and #22 services. Patient #2 patient #22. Employed primary nurse visiting aide supervision.  A review of patient patient had signed the on 10/1/13.  6. The agency policy and Responsibilities stated, "The home he and promote the exert follows the patient or her rights as a pating agency as follows be informed about the changes in the care to the lath agency shall a of disciplines that will frequency of visits protein the change in the reasonable discharge in the reasonable discharge.	10:25 AM, Employee W, RN, #21 was not receiving the d patient #22, who lived in received these baths. This tence, he indicated.  5 AM, Employee W, RN, #22 was the only one of receiving home health aide 1's visits were used for the W indicated he was the patient #22 and conducting the rights at the start of care titled "Patient Bill of Rights with no effective date that agency must protect roise of these rights as has the right to exercise his the patient has the right to the patient has the right to the patient has the right to the care to be furnished and of the patient has the right to the patient has the right to the patient has the right to the patient has the patient in advance furnish care, and the posed to be furnished they shall advise the patient plan of care, including	G f			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
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G 111	Continued From pag	e 11	G ·	111		
	The patient has the r clinical records main	ight to confidentiality of the tained by the HHA.				
	Based on policy revi review and interview the patient's right to d					
	The findings include:					
	Rights" with no effect privacy rights will be the time of admission Rights to inform pa rights of privacy. To privacy rights as spe-	titled "Patient Privacy tive date stated, "Patient presented to all patients at n with the Home Care Bill of atients of the agency of their accommodate patient cified in the privacy rule of an and Accountability Act				
	The texts are docume	oyee I, Registered Nurse. ented in printed form via ed with the employee roster				
	I .	6:33 PM unknown person , "Please call me. You have [patient #7]"				
	b. From Compla PM, "That's not the ri	ainant to Employee I at 7:45 ght password."				
	c. From Employ given].	ee I at 7:50 PM, [password				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		157596	B. WING	Ī			0
NAME OF PE	ROVIDER OR SUPPLIER	137336	I B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	06/	03/2014
					25 S JOLIET ST STE 312		
INCARE H	OME HEALTHCARE INC				OYER, IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 111	Continued From page	e 12	G	111			
	d. From complai you dear."	nant at 7:50 PM, " Thank					
	e. On 4/2/14 at complainant to Emplo seeing [patient #17] to	yee I , " Are going to be					
	3. On 5/30/14 at 3:15 AXXESS password o matched the texted p complaint documents	assword noted in the					
G 121	text was from her pho would only share pas	ICE W/ ACCEPTED	G ·	121			
	professional standard	must comply with accepted ls and principles that apply shing services in an HHA.					
	Based on observation procedures, the agent provided services in a agency's policies regarders.	not met as evidenced by: n, interview, and review of cy failed to ensure staff had accordance with the arding bag technique in 2 of ions (patient #19 and #20)					
	The findings include						
	1. On 6/2/14 at 2:10	PM, Employee E, home					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 56.125.	_		(	c
		157596	B. WING			06/	03/2014
	ROVIDER OR SUPPLIER			42	TREET ADDRESS, CITY, STATE, ZIP CODE 25 S JOLIET ST STE 312 YER, IN 46311		
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G 121	bag on patient #19's of 2. On 6/2/14 at 3:45 nurse, was observed patient #20's bed. Af and blood pressure c she replaced these st disinfecting them.  3. The agency proce Evaluation - Supply E effective date stated, hung from chair. Bar Equipment cleaned p appropriate."  4. On 6/3/14 at 11:55 indicated the visits abinfection control stand 484.14(c) ADMINIST. The administrator, who supervising physician under paragraph (d) of directs the agency's congoing liaison amon	erved to place her supply couch without a barrier.  PM, Employee I, registered to place her nursing bag on ter using her stethoscope uff to assess patient #20, upplies in the bag without  dure titled "Competency lag Technique" with no "Bag placed on surface or rier utilized, if appropriate rior to returning to bag, as  6 AM, the administrator love had not followed dards.  RATOR		133			
	Based on clinical rec document and policy review, observation, a	review, other document					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	:		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311		00/03/2014	
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G 133	Continued From page	e 14	G 1	33			
		to organize and direct the r 7 of 12 records (record #14 ewed.					
	The findings include						
	Regarding clinical red	cord #14					
	services had been profor 9 weeks during the 12/10/13 - 2/7/14 and 2/18/14 and 3/7/14. Transferred to the hose returned home on 2/2 discharge had occurred when the thouse of the completed by the RN observed kept as a completed by the RN observed kept as a completed to evidence and discharge summary by the complete the c	23/14. Neither a transfer or red to show that the patient and no resumption of care ne patient returned home. Fart of care assessment was on 2/26/14. The record was losed record in a file cabinet 15/30/14 at 9:10 AM, but by discharge assessment or nad been completed or that a lad been completed. It was attent had been discharged.					
	System" dated 2/21/r been hospitalized fro failing permacath.  b. On 5/28/14 a	itled "Community Healthcare 14 evidenced the patient had m 2/21/14 - 2/23/14 for a t 7 PM, patient #14 indicated I and that he / she had not					
	c. On 5/30/14 at indicated no hospital	9:10 AM, Employee C transfer or discharge oasis at patient #14's end of care.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		157596	B. WING		C 06/03/2014
	ROVIDER OR SUPPLIER	c		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311	1 00:00:20::
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
G 133	This was not following indicated the patient and had signed constant 2/26/14 and had been there were no order care provided.  d. On 5/30/14 and indicated the patient the agency and there assessment or disching had been transferred and returned home or resumption of care.  Regarding clinical record #15 and a diagnosis of diplans of care for the 2/19/14 - 4/19/14 and of care for 2/19/14 - 5/19/14 by the physiciate home health aided week for 9 weeks for According to employ the home health aided but had not turned in the constant indicated the patient indicated the pati	and policy. Employee C had signed the patient rights sent for a new start of care on an visited by the skilled nurse. It 2:26 PM, Employee C had been discharged from the was no discharge arge summary. The patient that to the hospital on 2/21/13 on 2/23/14. There was no  cord #15  5, start of care (SOC) 8/23/13 tabetes mellitus, included certification periods of d 4/20/14 - 6/18/14. The plan d/19/14 was signed on cian. This record evidenced the was to visit two times a these certification period. the A on 5/29/14 at 12:05 PM, the had been visiting the patient of documentation since the administrator was aware	G 13:	3	
	certification periods of 4/20/14 - 6/18/14 evilors was to visit two times these certification periods of the second certification periods	are for patient #15 for the of 2/19/14 - 4/19/14 and denced the home health aide is a week for 9 weeks for criod. On 5/29/14 at 12:05 is called by phone with			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		157596	B. WING _			C 06/03/2014	
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311		00/03/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
G 133	Employee C and Emplayers A indicated that Emplayers are. Employee S had tern did not give a date of stated, "Why she new know. There is a phy maintains contact wit investigation with our indicated that Employis responsible for this Employee I has made the agency but still new with documentation verificated Employee A indicated supervise the home in charge of supervision was pleased with this b. On 5/29/14 at indicated Employee S months ago and that seen her in the office c. On 5/29/14 at indicated visiting pati weekend. Employee sent in by Employee S knew that no docume months from the Employee S knew that no docume months from	ployee R present. Employee loyee C was sent to patient if Employee S, home health caring for this patient under imployee A indicated that ninated earlier this year, but termination. Employee A rer reported this, I don't visician order, but she he the patient. This is under the consultant." Employee A ree I, registered nurse (RN), is Employee A indicated that the progress in her work with reeds to make improvement with her care of the patients. If that Employee I does the althauties well and was in the of this aide. The patient is care from the agency.  4:30 PM, Employee R S had resigned a couple of no one from the agency had or at a visit with patient #15.  4:50 PM, Employee C ent #15 over the past C indicated that she was A to check on the services of the check on	G 1	33			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		157596	B. WING		06/03/2014
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311	1 00/00/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
G 133	Continued From pag	e 17	G 13	3	
	called via telephone Employee C. She in agency and caring for not turning in home is December 2013. Sh called her two weeks notes. This was the the agency. She ind not turned in the note trouble.  e. A clinical door titled "Physician orde no physician signatu HHA - pt [patient] ha	and spoke to writer and dicated still working for the preparent #15. She indicated health aide visit notes since he indicated Employee A sago telling her to turn in her only patient that she saw for icated she was sorry she had hes and asked if she was in sument in clinical record #15 her" with a date of 2/1/14 and re stated, "D/C [discontinue] is private duty assistance included the signature of strator.			
		documents were evidenced de care plans and were 2/18/14, and 4/18/14.			
	Regarding clinical re	cord #16			
	diagnosis of bronchit the certification period was an active record been transferred on The patient was liste	5, SOC 10/23/13 and a tis, included a plan of care for od of 4/21/14 - 6/19/14 and b. However, the patient had 5/16/14 and then discharged. It does not not be active patients list or, the clinical record was			
	Healthcare, inc. Pati	itled "Incare Home ent Survey Census" with an 8/14 included patient #16's			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		157596	B. WING			·	C 03/2014
	ROVIDER OR SUPPLIER	;		4	TREET ADDRESS, CITY, STATE, ZIP CODE 25 S JOLIET ST STE 312 DYER, IN 46311	1 00/	03/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 133	10/23/13 and certifica 6/19/14, diagnosis of skilled nursing and he b. On 6/2/14 at 1 indicated the discharge computer software prisince she was still lead program.  Regarding clinical red 4. A document titled inc. Patient Survey Cof 5/28/14 included p #, date of birth, SOC certification period of benign hypertension, nursing and home he a. On 5/29/14 at alternate administrate #17's record.  b. On 5/30/14 at Employee C was una record.  c. On 5/30/14 at agency, Employee R the discharged record health aide visit had opatient had been trar that date. There was assessment evidence	ate of birth, SOC date as ation period of 4/21/14 - bronchitis, and disciplines of ome health aide.  0:25 AM, Employee A ge was pending in the rogram called AXXESS, arning the features of the  cord #17  'Incare Home Healthcare, ensus'' with an effective date atient #17's name, medicare date as 2/2/14 and 4/3/14 - 6/1/14, diagnosis of and disciplines of skilled	G	133			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDI			(	
		157596	B. WING			06/	03/2014
	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 133	Registered Nurse, inc transferred to the hos now discharged. No assessment or summ	licated the patient had been pital on 4/29/14 and was transfer or discharge ary had been completed.  :35 PM, Employee A, the ed the patient was	G	133			
	that patient #18's record found. On 6/2/14 at 1 record was located ar summary and assess	PM, Employee C indicated ord was not able to be 2:20 PM, Patient #18's					
	neoplasm, included a certification period of payment source was plan of care indicated skilled nurse visits 1 - and HHA visits for pershowers 1 - 2 times a were also HHA visits 4/3/14, 4/9/14, 4/11/14 and 4/24/14 after the There was an aide care	, SOC 10/4/13 and and diagnosis of brain plan of care for the 2/1/14 - 4/1/14. The listed as Medicare. This the patient was to receive 2 times weekly for 9 weeks					
	7. Clinical record #22	, SOC 10/1/13 and a					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		157596	B. WING			C 6/03/2014
	ROVIDER OR SUPPLIER  OME HEALTHCARE IN	С		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311		0.00/2014
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
G 133	for the certification pand payment source record were HHA vis name of patient #21 this plan of care was of 1 time a week for week x 9 weeks. H4/4/14, 4/8/14, 4/10/4/25/14, 4/29/14, 4/3/5/13/14, and 5/15/14 occurred on 3/25/14 5/7/14, 5/14/14, and patient #21 were als from the following defined that she with patients #21 and with patients #21 and with patients #21 and patients #21 and with patients #21 and patie	egia, included a plan of care period of 3/30/14 - 5/28/14 as Medicare. Included in the sits from record #21 with the documented. Ordered on a the skilled nurse frequency of 9 weeks and HHA 2 times a HHA visits occurred on 4/2/14, 14, 4/15/14, 4/17/14, 4/23/14, 30/14, 5/1/14, 5/7/14, 5/9/14, 4. Skilled nurse visits of the skilled nurse visits of in this record. These were entes: 4/9/14, 4/11/14, 22/14, 4/24/14, 4/30/14, and 105 PM, the administrator as looking into this situation of #22. She stated, "We are his. [The patient] has private	G 133	3		
	"Agency will docume the patient. This do completed by the di- by the skilled profes managing the patien there is an accurate provided, patient res care to document care, modifications to interdisciplinary invo- the services ordered completed the day s	n no effective date stated, ent each direct contact with ocumentation will be rect caregivers and monitored sional responsible for nt's care to ensure that record of the services sponse and ongoing need for conformance with the plan of				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		157596	B. WING				03/2014
	ROVIDER OR SUPPLIER		<u>. I</u>	4	STREET ADDRESS, CITY, STATE, ZIP CODE 125 S JOLIET ST STE 312 DYER, IN 46311	1 00/	03/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 133 G 141	Continued From page after the care has bee 484.14(e) PERSONN	en provided."		133 141			
	Personnel practices a supported by appropr policies.	and patient care are iate, written personnel					
	Personnel records inclicensure that are kep	clude qualifications and t current.					
	Based on personnel interview, the agency personnel policies we employee files review						
	Findings						
	hire 8/10/07 and unkr	e health aide (HHA), date of nown first patient contact, annual evaluation had been 2.					
	patient contact in 200 annual evaluation sine	, date of hire 4/9/09 and first 9, failed to include an ce 2010 and a competency been completed upon hire.					
	hire 3/28/14 and first	stered Nurse (RN) , date of patient contact 4/10/14, ninal history or completed					
		late of hire 3/21/14 and first 4, evidenced a criminal					

	OF DEFICIENCIES CORRECTION				(X3) DATE SURVEY COMPLETED	
		157596	B. WING			C 06/03/2014
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311		00/03/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
G 141	examination had been some screening prior to proper preemployment physical performed by a physical performed by state late. The agency policity is a state of the conducted for all employment and at late. The agency policity with no effective date be established and in the personnel record criminal history and required by law [IC 1]. The agency policity with no effective date be established and in the personnel record criminal history and required by law [IC 1]. The agency policity services with no effective will provide direct care. On 5/29/14 at 12: indicated the person complete.	stated, "Personnel Records" estated, "Personnel files will maintained for all personnel of titled "Personnel Records" estated, "Personnel files will maintained for all personnel of to an employee will include d background checks as 6-27-2]."  y titled "Home Health Aide ective date stated, "Only tho meet required standards re."	G 14			
G 156	complete.	CE OF PATIENTS, POC,	G 18	56		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG	l(×	3) DATE SURVEY COMPLETED
		157596	B. WING			C <b>06/03/2014</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311	I	06/03/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOWS CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
G 156	This CONDITION is Based on clinical recreview, and interview agency failed to ensure addressed and being agency in the patient' 12 patient records revito affect all patients of failed to ensure treatrous been provided in accorders in 8 of 12 recorders in 8 of 1	not met as evidenced by: ford and agency policy it was determined the fore patients needs were met adequately by the forespield properties in 6 of forewed creating the potential of the agency (See G 157), ments and services had fordance with physician's fords reviewed creating the forespield to ensure the plan of fine physician timely and felements for 8 of 12 records fential to affect all the forespield to ensure the plan of fine physician timely and felements for 8 of 12 records fential to affect all the fine G 159), and failed to forespield to affect all of the finespield to affect all the finespie	G 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		157596	B. WING _			C <b>06/03/2014</b>
	ROVIDER OR SUPPLIER	С		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311		00/00/2014
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 157	Based on agency direcord review, policy agency failed to enside addressed and being agency in the patien 12 patient records (for eviewed).  Findings include:  1. Clinical record #1. 10/23/13, included a certification period or orders for home heat week for 9 weeks. Huntil May 14, 2014.  a. On 4/23/14 a indicated having a caddressed by the accomplained of not reconthe plan of care a met.  b. On 5/29/14 a Registered Nurse (Find not been followed missing from the clinical record #evidenced the patien rights at the start of complaint document and the patient was discharge or ceasing a. On 5/28/14 a contract to the patient was discharge or ceasing a. On 5/28/14 a contract to the patient was discharge or ceasing a. On 5/28/14 a contract to the patient was discharge or ceasing a. On 5/28/14 a contract to the patient was discharge or ceasing a. On 5/28/14 a contract to the patient was discharge or ceasing a. On 5/28/14 a contract to the patient was discharge or ceasing a. On 5/28/14 a contract to the patient was discharge or ceasing a. On 5/28/14 a contract to the patient was discharge or ceasing a. On 5/28/14 a contract to the patient was discharge or ceasing a. On 5/28/14 a contract to the patient was discharge or ceasing a. On 5/28/14 a contract to the patient was discharge or ceasing a. On 5/28/14 a contract to the patient was discharge or ceasing a.	not met as evidenced by: ocument review, clinical of review, and interview, the ure patients needs were g met adequately by the t's place of residence in 6 of 12, 14, 16, 17, 19, 22)  2, start of care (SOC) plan of care for the f 4/21/14 - 6/19/14 with Ith aide (HHA) 1 - 2 times a However, no visits occurred  4 4:23 PM, the patient complaint that had not been Iministrator. The patient had acciving aide visits as ordered and not having his / her needs  4 10:12 AM, Employee C, 2N), indicated the plan of care and and HHA visits were accided and HHA visits were accided and received the patient care and failed to have a ed, investigated, or resolved not told of a pending	G 1	57		

PRINTED: 06/24/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY PLETED
		157596	B. WING				C <b>03/2014</b>
	ROVIDER OR SUPPLIER  OME HEALTHCARE INC		1	42	TREET ADDRESS, CITY, STATE, ZIP CODE 25 S JOLIET ST STE 312 IYER, IN 46311	1 007	03/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 157	filing a complaint with requested that Employer director of nursing, in This never occurred on numerous phone calls the person the patient Employee A. At one call on speaker phone Employee A talking all patient #14 and compatient #14 and compatient #14 and compatient #15 and courring was would return call, but and ever did investigate complaint. Patient #15 supplies for an abdomot receive any more agency staff stopped discussing this failure Patient #14 indicated hemodialysis at the standard the patient. The patient had Evaluation ordered on to evidence that the patient's refusal for the community resources patient. No social wor	2014. Patient #14 indicated the office personnel and yee A, the administrator and vestigate the complaint. despite patient #14's is to the office and being told to needed to speak to was call, the office staff put the eand patient #14 could hear bout not having time to call blaining that the patient. Employee A indicated on er intentions to call when the side and at that time she she never did return a call ate or resolve the patient's 4 indicated needing hinal fistula dressing and did of these supplies when the visits without notice or to visit with her / him. being on home tart of care with the agency.  10:25 AM, Employee C, RN, is needs had not been met.  6, start of care 10/23/13 and is, included a plan of care for d of 4/21/14 - 6/19/14 which patient's needs had been a Social Worker (MSW) in 4/21/14. The record failed shysician was notified of the re social work visit. No were made available to the re k interventions occurred. It is a social work visit. No were made available to the re k interventions occurred. It is a social was contacted and did not have to the resocial work visit.	G	1157			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		157596	B. WING			C 06/03/2014	
	ROVIDER OR SUPPLIER	:		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311	1 00/00/2014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
G 157	Continued From page		G 1	57			
	physician wrote the formula physician wrote the formula physician wrote the physician wrote the formula physician wrote the physician	t 6:52 PM, the home collowing clinical note: we a more appropriate and will order social services n a skilled facility cannot collows."					
	practical nurse (LPN) clinical note, "Will co	t 5:15 PM, the licensed b, Employee C, stated in a entact SS [Social Services itions]." The record failed to ed.					
	registered nurse (RN under Care coordinat of nursing, "Patient n MD for possible assis placement. Need for frequency for SN [ski	e written by Employee W, ), on 5/13/14 at 11:35 AM tion to Employee A, director eeds evaluation by home sted living or nursing home MSW also relayed. Current lled nurse] and HHA needs and DON [director of ht this PM."					
	indicated the patient	11:05 AM, the administrator had refused social work as no documentation about his refusal occurred.					
	written by Employee stated, "Pt [patient] a arouseable 911 no	t 11:30 AM, a clinical note W, Registered Nurse, ssessment lethargic but tified for ambulance transfer n." Patient was transferred					
	certification period of	7, SOC 10/2/12 with a 4/3/14 - 6/1/14 included an care that stated, "Physician's					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		157596	B. WING _			C <b>06/03/2014</b>	
	ROVIDER OR SUPPLIER	С		STREET ADDRESS, CITY, STATE, ZIP COD 425 S JOLIET ST STE 312 DYER, IN 46311	<b>I</b>	00/03/2014	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
G 157	dated 4/2/14 and signed by the physical a. On 5/30/14 a Registered Nurse, in on 4/24/14 and then with a knife. Employe called with an update physician. Employe this incident and did informal caregiver to emergency room whand stayed several of the companion of t	eval [evaluation]" This was used by Employee A, rector of nursing, and not sian.  at 4 PM, Employee I, adicated the patient had fallen cut self on arms on 4/29/14 yee E, the home health aide, e and employee I called the e I did not write any notes on not write a transfer oasis. An wok the patient to the here the patient was admitted days.  at 4:45 PM, Employee C, the for indicated the social work in the record.  1:30 PM, Employee A had refused to see a social no order or other e doctor about this refusal.  9, start of care 4/5/2014, had rights at the start of care and laint documented, lived.  10 PM, patient #19 physical therapist had called ad said that a visit would No visit had occurred. The	G 1	57			
	6. Clinical record #2	t no follow- up had occurred.  2, start of care 10/1/13,  1t had received the patient					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		157596	B. WING _			C <b>06/03/2014</b>
	NAME OF PROVIDER OR SUPPLIER  INCARE HOME HEALTHCARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311		00/03/2014
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 157	Complaint documents  On 6/3/14 at 11 patient #22 and infor indicated calling Empthe patient was receishowers that had beindicated receiving nomplaint. In Februa also complained and plan of care was alternated that he /she should be follow up with this coattorney indicated las administrator about the showers as requested.  8. A review of the coevidence any investigned and investigned and patient #12, #14, #19  9. The agency policy Process" with no effect agency cannot fulfill referral will be made community resources notified."  10. The agency documents and Responsistated, "Be admitted care you need."	care and failed to have a sed, investigated, or resolved.  AM, the power of attorney for mal caregiver of patient #22 ployee A with a complaint that ving sponge baths and not en agreed upon. He/she of follow up with his ry, the power of attorney had requested that any time the red or days were changed be contacted. There was no entire many time the red or days were of st week to talk to the he patient not receiving down and getting no response.  Implaint log failed to gation or other erning the complaint filed by 10, #20, #22.  It titled "Patient Admission bective date stated, "If the the required health need, a to other appropriate is and referral source will be a sument titled "Patient Bill of bilities" with no effective date only if we can provide the sission package contained a	G 1			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		157596	B. WING		C 06/03/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311	00/03/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
G 158 G 158	484.18 ACCEPTANO MED SUPER  Care follows a written	ce of Patients, Poc,  n plan of care established ewed by a doctor of medicine,	G 15 G 15			
	Based on clinical red review and interview services and treatme accordance with phy records reviewed (#7	not met as evidenced by: cord and agency policy , the agency failed to ensure ents had been provided in sician's orders in 8 of 12 /, 12, 13, 14, 15, 16, 19, 20) I to affect all of the agency's				
	with a diagnosis of C included a plan of ca of 3/23/14 - 5/21/14 therapy (OT) visits. frequency for the visi 3/25/14, 3/27/14, 4/3 Skilled nurse visits w of care. A nurse visit show that the nurse ordered on the plan of or edema and periplifailed to complete a limit of the complete a limit of	n, start of care (SOC) 7/26/13 congestive Heart Failure, re for the certification period with orders for occupational The orders failed to include tts which occurred on /14, 4/8/14, and 4/10/14. Here also ordered on the plant ton 4/11/14 at 9 AM, failed to had completed the tasks of care including assessing heral circulation. The nurse body system assessment the nurse failed to complete a				
		55 PM, Employee C, N) indicated the visits above n of care.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		157596	B. WING _			C 06/03/2014
	ROVIDER OR SUPPLIER	:		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311	<b> </b>	00/03/2014
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 158	Continued From pag	e 30	G 1	58		
	diagnosis of benign in plan of care for the completed and was read silving. The only aide on 5/29/14 at indicated the plan of completed and was rand skilled nurse visits were present for the b. On 5/29/14 at registered nurse (RN piece of paper with vertical paper did not indicated the dapaper did not indicated the dapaper did not indicated care had been comp	weekly weights, assess and agement, proper body y measures, to instruct on an ambulating, and to it to see a podiatrist. No ere completed in the clinical ealth aide was to visit 1 - 2 ist with activities of daily visit notes in the record were 14. No other aide notes current certification period.  10:15 AM, Employee C care had not been not part of the clinical record its and home health aide record.  2:00 PM, Employee I, ), was observed to have a isit notes for the past two is paper. She indicated she evisit until later at home. Head into about 8 sections and after were recorded. The evisit was observed to the plan of leted besides vital signs. Sesessments or instructions				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		157596	B. WING			C <b>06/03/2014</b>
	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311	l	06/03/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 158	c. On 6/3/14 at 2 the skilled nurse visit record and document a visit note or in the surse visits used by sindicated Employee I her skilled nurse visit policy.  3. Clinical record #1: plan of care for the construction of care for the construction of care on 5/10/made on 4/15/14, 4/15/17/14, 5/20/14, and frequency of skilled recare.  On 5/30/14 at 2: indicated the skilled replan of care.  4. Clinical record #1: disruption evidenced occurred on 8/12/13. The record evidenced	PM, Employee A indicated so were missing from the tation of a visit should be on software program for skilled the agency. Employee A had not been documenting so timely or according to a society of the	G 15	8		
	was signed on 1/16/1 of care after this certino orders for skilled redocumented on 2/18/ start of care assessment on 2/26/14.  On 5/30/14 at 9: there were no orders	4. There was no other plan fication period. There were nurse visits which were 14 and 3/7/14. An oasisment was completed by the 45 AM, Employee C indicated on the plan of care for the at occurred on 2/18/14 and				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3	COMPLETED	
		157596	B. WING			C <b>06/03/2014</b>	
	NAME OF PROVIDER OR SUPPLIER  INCARE HOME HEALTHCARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE  425 S JOLIET ST STE 312  DYER, IN 46311		06/03/2014	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
G 158	3/7/14 and the oasic completed by the R  5. Clinical record #1 diagnosis of diabete care for the certifica 2-18-14 (HHA to vis skilled nurse 1 - 2 ti 4/19/14 (HHA 2 time (SN) 1 times a week). 4/19/14 was signed The home health ai patient but had not December 2013. The but the concern was documented. Home made since Decemed documentation in the patient had phy occupational therapand 5/8/14 and these was no documentation visits did not occur.  a. On 5/29/14 and these was no documentation occur.  a. On 5/29/14 and these was no documentation in the patient had phy occupational therapand 5/8/14 and these was no documentation in the patient had phy occupational therapand 5/8/14 and these was no documentation in the patient had phy occupational therapand 5/8/14 and these was no documentation in the patient had phy occupational therapand 5/8/14 and these was no documentation in the patient had phy occupational therapand 5/8/14 and these was no documentation in the patient had phy occupational therapand 5/8/14 and these was no documentation in the patient had phy occupational therapand 5/8/14 and these was no documentation in the patient had phy occupational therapand 5/8/14 and these was no documentation in the patient had phy occupational therapand 5/8/14 and these was no documentation in the patient had phy occupational therapand 5/8/14 and these was no documentation in the patient had phy occupational therapand 5/8/14 and these was no documentation in the patient had phy occupational therapand 5/8/14 and these was no documentation in the patient had phy occupational therapand 5/8/14 and these was no documentation in the phy occupation in the phy occ	s start of care assessment N on 2/26/14.  5, SOC 8/23/13 and a es mellitus, included plans of ation periods of 12-21-13 - ati 1 - 2 times a week and and mes a week), 2/19/14 - es a week and skilled nurse at a week and at a very and at a week and at a very a ver	G 15	8			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	` ′	(X3) DATE SURVEY COMPLETED	
		157596	B. WING			C <b>06/03/2014</b>	
	NAME OF PROVIDER OR SUPPLIER  INCARE HOME HEALTHCARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311		00/03/2014	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
G 158	this. Employee A in made progress in h still needs to make documentation with Employee A indicate supervise the home charge of supervision was pleased with the b. On 5/29/14 a indicated Employee months ago and the seen her in the office c. On 5/29/14 a indicated visiting parameters are considered that she will be check on the service Employee C indicated that she will be care for patient #15 patient was cognitive Employee S was proposed to the agency and indicated not turning notes since Decemine Employee A called to turn in her notes.	oyee I, RN, is responsible for idicated that Employee I has er work with the agency but	G 15	8			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	COMI	(X3) DATE SURVEY COMPLETED	
		157596	B. WING		1	C / <b>03/2014</b>	
	NAME OF PROVIDER OR SUPPLIER  INCARE HOME HEALTHCARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311	1 03/05/2014		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
G 158	Continued From pag	e 34	G 158	3			
	she had not turned ir was in trouble.	n the notes and asked if she					
	I .	t 1:10 PM, Employee C care was not followed and ver occurred.					
	titled "Physician orde no physician signatu HHA - pt [patient] ha	ument in clinical record #15 er" with a date of 2/1/14 and re stated, "D/C [discontinue] s private duty assistance icluded the signature of strator.					
	_	I documents in the record de care plans and were 1/18/14, and 4/18/14.					
	diagnosis of bronchit nurse used triple ant patient's skin tear on	6, start of care 10/23/13 and is, evidenced the skilled ibiotic ointment on the without obtaining an order AM. It was not documented was.					
	I .	20 AM, Employee A, the ted there was no order for					
	included a plan of ca of 4/17/14 - 6/15/14. evidence the patient	ive chronic bronchitis, re for the certification period					
	On 6/3/14 at 2 F	PM, Employee A indicated ccur.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	(X3) DATE SURVEY COMPLETED			
		157596	B. WING		C 06/03/2014	
	NAME OF PROVIDER OR SUPPLIER  INCARE HOME HEALTHCARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 125 S JOLIET ST STE 312 DYER, IN 46311	00/03/2014	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
G 158	diagnosis of chronic a plan of care for the -6/3/14, evidenced treatment and OT evidenced witten on 5/5/14 and occurred on 5/10/14  On 6/3/14 at 2:4 administrator, indicatof the therapy site at records.	20, SOC 4/5/14 and a airway obstructive, included a certification period of 4/5/14 orders for PT evaluation and valuation and treatment.  occurred. A new order was d an evaluation for PT.  No OT visits occurred.  15 PM, Employee A, the ted they had been locked out and could not access patient	G 158			
	with no effective daticare is developed for admission and signed appropriate time frainclude prompt reported to the following appropriate the following appropriate the plan of the following appropriate the following appropriate time following appropriate time fragments appropriate time frag	e stated, "A physician plan of r each patient at the time of ed by the physician in the me agency responsibilities ring of a change in patient of a physician plan of care."  cy titled "Scope of Practice" e stated, "Agency will provide compliance with acceptable ds for the Home Care ne state and federal laws and rformance improvement care will be provided under ablished by a physician wer services based on each				

PRINTED: 06/24/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		157596	B. WING				03/2014
	ROVIDER OR SUPPLIER			4:	TREET ADDRESS, CITY, STATE, ZIP CODE 25 S JOLIET ST STE 312 YER, IN 46311	1 001	00/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 158	members The plareviewed to ensure the met, and updated as days An individualist the physician shall be receiving home health services. The plan of full to include type, all visits, services reprocedures treatmed orders will be reviewed and agency personned the patient's conditional time every 60 days. If physician to any changle alter the plan of care, shall be obtained from changes in the plan of care, shall be obtained from changes in the plan of care development required, for prognosis, rehabilitati limitations, activities prequirements, medical safety measures to prognosis, rehabilitati limitations for timely any other appropriate.  This STANDARD is replan of care was signal of care was signal to the safety of the agency the agency the agency the agency that is the safety measures to prognosis, rehabilitating the safety measures to prognosis the agency of the safety measures to prognosis, rehabilitating the safety measures to prognosis, rehabilitations, activities prequirements, medical safety measu	ant / family and health team an will be consistently at the patient needs are necessary at least every 60 zed plan of care signed by required for each patient and personal care for care shall be completed in frequency, and duration of nedications, treatments, and by the attending physician as often as the severity of a requires, but at least one Professional staff alert the ages that suggest a need to Verbal telephone orders in the patient's physician for for care."  CARE  Peloped in consultation with res all pertinent diagnoses, as, types of services and requency of visits, on potential, functional permitted, nutritional attons and treatments, any rotect against injury, discharge or referral, and		158			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		DATE SURVEY COMPLETED
		157596	B. WING _			C 06/03/2014
	ROVIDER OR SUPPLIER	C		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311	<b>_</b>	00/03/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
G 159		e 37 7, 12, 13, 14, 15, 16, 17, 19) affect all the agency's	G 1	59		
	patients. Findings	anostan ino agono, o				
	with a diagnosis of C included a plan of ca of 3/23/14 - 5/21/14 physician. The plan period of 5/22/14 - 7 completed on 5/30/1 included orders for olacked frequency of on the plan of care fol lacked the reason the	4 at 3 PM. The plan of care ccupational therapy, but they the visits. The medication list or these certification periods e medications were given for cations including polyethylene				
	Registered Nurse (R was not completed by plan of care for the complete. The occulacked frequency of					
	indicated the plan of	t 3 PM, Employee C care for the most recent as not completed timely.				
	diagnosis of benign the physician had sign certification period of 6/1/14. This plan of of the as needed me hydrocodone / aceta	2, SOC 10/23/13 with a hypertension, evidenced that gned the plan of care for the f 4/21/14 - 6/19/14 until care failed to list the purpose dications including minophen 10 - 325 mg - 8 hours as needed and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		157596	B. WING			C 06/03/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311	'	00/00/2014
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 159	Continued From page	÷ 38	G 15	9		
	many tablets a day w time of day the medic	let prn po (by mouth). ien did not evidence how ould be given and at what eation would be given.  10:15 AM, Employee C				
	indicated the plan of a timely manner.	care had not been signed in				
	b. On 5/30/14 at indicated the plan of medications listed co					
	diagnosis of chronic properties for the certification per and also for 5/28/14 evidence a complete patch was listed with route of administratio 5/28/14 - 7/26/14 evidence to assess the patient' effectiveness of pain pain management the	medications and current erapy at every visit. Skilled				
	better pain control. T	comes severe to achieve here were no measurable goals listed on this plan of				
	indicated the medicat failed to include the d administration for the that no measurable g the patient's pain leve	26 PM, Employee C ion list on the plan of care ose, frequency, and route of medication: Fentanyl and oals were listed to assess els and understanding of the ntrol that was to occur.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		157596	B. WING _			C 06/03/2014
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311	•	00/03/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
G 159	disruption evidenced occurred on 8/12/13 The record evidence certification period of not signed by the phromator of the plan of period. There were evisits which were down at 3/7/14. An oasis star completed by the RN On 5/30/14 at 90 there was no plan of visits that occurred of the oasis start of care as RN on 2/26/14.  5. Clinical record #15 diagnosis of diabetes care for the certificat 2-18-14 (HHA to visits skilled nurse 1 - 2 time 4/19/14 (HHA 2 times week) and 4/20/14 week). The plan of the own of the certificat occurred on physician signature HHA - pt [patient] has since 12/13." This in Employee A, administration period occurred the certification period occurred to the certification period	4 with a diagnosis of wound two starts of care. One and the other on 2/26/14. d a plan of care for the f 12/10/13 - 2/7/14 which was ysician until 1/16/14. There care after this certification no orders for skilled nurse cumented on 2/18/14 and rt of care assessment I on 2/26/14.  45 AM, Employee C indicated care for the skilled nurse in 2/18/14 and 3/7/14 and the esessment completed by the sessment completed by the sessment completed by the 15, SOC 8/23/13 and a similar melitus, included plans of ion periods of 12-21-13 - t 1 - 2 times a week and ines a week), 2/19/14 - tes a week and SN 1 times a 6/18/14 (SN one times a sare for 2/19/14 - 4/19/14 by the physician.  The stated, "D/C [discontinue] is private duty assistance included the signature of	G 1	59		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY
			7 56.25.	_		(	c
		157596	B. WING			06/	03/2014
	ROVIDER OR SUPPLIER  OME HEALTHCARE INC			4	STREET ADDRESS, CITY, STATE, ZIP CODE 125 S JOLIET ST STE 312 DYER, IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 159	Continued From page		G	159			
		06 AM, Employee A, ed the plan of care was not					
	certification period of evidence the frequency which occurred on 4/3	This plan of care was not					
	a. On 5/30/14 at indicated the plan of o	1:15 PM, Employee C care was not signed.					
		1:30 PM, Employee A cy of skilled nurse visits was an of care.					
		ve chronic bronchitis, re for the certification period This plan of care was not					
	On 6/3/14 at 2:15 the plan of care was r manner.	5 PM, Employee A indicated not signed in a timely					
	effective date stated, furnished under the s physician. the plan o comprehensive asses provided by the patier members The plareviewed to ensure the met, and updated as	ssment and information nt / family and health team					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				•		(	
		157596	B. WING			06/	03/2014
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
INCARE H	OME HEALTHCARE INC				125 S JOLIET ST STE 312 DYER, IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 159	receiving home health services. The plan of full to include type, all visits, services reprocedures treatmed orders will be reviewed and agency personned the patient's condition time every 60 days. If physician to any channel alter the plan of care. shall be obtained from changes in the plan of 484.30 SKILLED NUMBER 1 This CONDITION is a Based on clinical receiving the plan of care.	quired for each patient in and personal care if care shall be completed in ifrequency, and duration of inedications, treatments, ient goals signed physician iel by the attending physician iel as often as the severity of in requires, but at least one if perfessional staff alert the inges that suggest a need to if verbal telephone orders in the patient's physician for if care."		159			
	agency failed to ensulated been provided in orders in 5 of 12 recording potential to affect all of patients (See G 170) comprehensive assess within 48 hours of the a hospital admission of 12 records reviewed affect all the patients of G 172), and failed to coordinated patient careviewed and promptile any changes that sug	re skilled nursing services accordance with physician's rds reviewed creating the of the agency's 72 current failed to ensure a sement had been completed patient's return home from of 24 hours or more in 1 of creating the potential to who were hospitalized (See ensure the registered nurse are for 7 of 12 records y alerted the physician to gested a need to alter the 2 records reviewed with the of the agency's active					

· · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		157596	B. WING			C 06/03/2014		
	ROVIDER OR SUPPLIER	:		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311	·	00/00/2011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
G 168	Continued From page	e 42	G 16	58				
G 170	resulted in the agenc	Condition of Participation og Services.	G 17	70				
	The HHA furnishes sl accordance with the p	killed nursing services in plan of care.						
	Based on clinical rec review and interview, skilled nursing service accordance with phys records reviewed (#7	not met as evidenced by: cord and agency policy the agency failed to ensure es had been provided in sician's orders in 5 of 12 7, 12, 13, 14, 16) creating the of the agency's patients that g services.						
	Findings							
	with a diagnosis of Coincluded a plan of call of 3/23/14 - 5/21/14. AM failed to show the orders on the plan of edema and periphera failed to complete a burney of the comp	start of care (SOC) 7/26/13 ongestive Heart Failure, re for the certification period. A nurse visit on 4/11/14 at 9 at the nurse had completed care including assessing for all circulation. The nurse body system assessment he nurse failed to complete a						
		55 PM, Employee C, N) indicated the visits above n of care.						
	2. Clinical record #12	2, SOC 10/23/13 with a						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED
		157596	B. WING			C 06/03/2014
	ROVIDER OR SUPPLIER	С		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 170	plan of care for the cillian of care for the cillian of care for the cillian of care for the certificate 6/19/14. This plan of nurse was to visit the weeks to assess pais shortness of breath, instruct on pain man mechanics and safe proper foot wear whencourage the paties skilled nurse visits we record.  a. On 5/29/14 a indicated the plan of completed and was and that skilled nurse record.  b. On 5/29/14 a was observed to have with visit notes for the this paper. She indicated the date were reindicate what part of completed besides was essessments or instructed.  c. On 6/3/14 at that the skilled nurse record and document a visit note or in the	hypertension, evidenced no certification period of 4/21/14 at 10:15 AM. On 6/2/14 at ecord did contain a plan of tion period of 4/21/14 - of care evidenced the skilled e patient 1 times a week for 9 in level, instruction on weekly weights, assess and agement, proper body ty measures, to instruct on en ambulating, and to int to see a podiatrist. No erere completed in the clinical	G 17	70		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG	' '	(X3) DATE SURVEY COMPLETED	
		157596	B. WING _			C 06/03/2014
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311	<b>!</b>	00/03/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	IVE ACTION SHOULD BE ED TO THE APPROPRIATE	
G 170	Continued From page		G 1	70		
		had not been documenting is timely or according to				
	plan of care for the co - 5/27/14 that was ele Employee I on 3/25/1 plan of care on 5/10/ made on 4/15/14, 4/5 5/17/14, 5/20/14, and	3, SOC 3/29/14, evidenced a ertification period of 3/29/14 ectronically signed by 4. The physician signed this 14. Skilled nurse visits were 22/14, 4/29/14, 5/9/14, 5/27/14. There was no nurse visits on this plan of				
		25 PM, Employee C nurse had not followed the				
	disruption evidenced occurred on 8/12/13 and The record evidenced certification period of was signed on 1/16/1 of care after this certino orders for Skilled documented on 2/18	4 with a diagnosis of wound two starts of care. One and the other on 2/26/14. d a plan of care for the 12/10/13 - 2/7/14, which 4. There was no other plan ification period. There were nurse visits which were 3/14 and 3/7/14. An oasis nent completed by the RN on				
	that there was no pla					
	diagnosis of bronchit	6, start of care 10/23/13 and is, evidenced the skilled biotic ointment on the				

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		157596	B. WING			C <b>06/03/2014</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311		00/03/2014
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 170	Continued From partial patient's skin tear of on 5/13/14 at 11:35 where the skin tear.  On 6/2/14 at 11 administrator, indicated this treatment.  6. The agency policy with no effective das services that are in professional standard Industry as well as identified agency pestandards patient the plan of care estagency staff will deliberate patient's unique and 7. The agency policy effective date stated furnished under the physician. the plan comprehensive ass	ge 45 In without obtaining an order AM. It was not documented was.  I:20 AM, Employee A, the lated there was no order for  y titled "Scope of Practice" te stated, "Agency will provide compliance with acceptable rds for the Home Care the state and federal laws and leformance improvement to care will be provided under lablished by a physician liver services based on each dindividual needs."  by titled "Plan of Care" with an di, "Home care services are supervision of the patient's of care is based on a lessment and information	G 17	·		
	members The previewed to ensure met, and updated a days An individua the physician shall preceiving home heaservices. The planfull to include typ all visits, services procedures treatrorders will be reviewed and agency person the patient's condition.	ent / family and health team blan will be consistently that the patient needs are is necessary at least every 60 alized plan of care signed by be required for each patient lth and personal care of care shall be completed in e, frequency, and duration of medications, treatments, ment goals signed physician wed by the attending physician nel as often as the severity of on requires, but at least one Professional staff alert the				

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		157596	B. WING		064	
	ROVIDER OR SUPPLIER  OME HEALTHCARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311	1 06/0	03/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
G 170	physician to any charalter the plan of care. shall be obtained from changes in the plan of care. Shall be obtained from changes in the plan of changes with no effect under the supervision in accordance with a Care [Physician's Ordowhether a service registered nursing practice of the patient, and accordance with a care inherent complexity of the patient, and accordance with a care inherent complexity of the patient, and accordance with a care inherent complexity of the patient, and accordance inherent complexity of the patient, and accordance inherent complexity of the patient nursing practice of the care plan requiring specialized appropriate preventation of the condition and needs appropriate preventation of the condition and needs appropriate of the condition and needs appropriate preventation and needs appropriate preve	ges that suggest a need to Verbal telephone orders in the patient's physician for if care."  titled "Skilled Nursing ctive date stated, "Skilled be provided by a Registered Practical / Vocational Nurse of a Registered Nurse and medically approved Plan of lers]. In determining uires the skills of a Nurse, ty of the service, condition bepted standards of medical will be considered The erforms the initial degularly reevaluates the ordinates necessary e plan of care and and updates to the plan of in d. Provides services inursing skill and initiates ive and rehabilitative informs the physician and anges in the patient prepares clinical and  THE REGISTERED  regularly re-evaluates the	G 17			
	Based on clinical rec	ord and document review ency failed to ensure the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		157596	B. WING			06/	03/2014
	ROVIDER OR SUPPLIER			42	TREET ADDRESS, CITY, STATE, ZIP CODE 25 S JOLIET ST STE 312 YER, IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 172	when the patient retu	e 47 aluated the patient's needs rned home from a hospital records reviewed (patient	G	172			
	to evidence a comprebeen completed within discharge from the hot failing permacath. The patient had been the hospital.  2. A document titled System" and dated 20 had been hospitalized.	t, start of care 8/12/13, failed shensive assessment had in 48 hours of the patient's ospital for treatment of a ne record failed to evidence discharged when entering  "Community Healthcare (21/14 evidenced the patient of from 2/21/14 - 2/23/14 for					
G 176	the patient had been on 2/23/14 and had n he/she returned home 484.30(a) DUTIES ONURSE  The registered nurse progress notes, coord	F THE REGISTERED  prepares clinical and dinates services, informs the ersonnel of changes in the	G	176			
	Based on clinical rec the agency failed to e coordinated patient ca	not met as evidenced by: ord review and interview, ensure the registered nurse are for 7 of 12 records 16, 17, 21, and 22) and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	С		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311	1 00/03/2014
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLETION
G 176	promptly alerted the that suggested a ne 1 of 12 records revies Findings  1. On 5/28/14 at 11 alternate director of any patients with oth 2. Clinical record # 10/23/13 with a diagincluded a plan of co of 4/21/14 - 6/19/14 aide services, skilled clinical record failed between the skilled or the podiatrist.  On 5/29/14 at 1 indicated no coordin 3. Clinical record # diagnosis of wound patient was receivin skilled nurse service to evidence coordinate facility and the skilled a. On 5/28/14 abeing on home hem completing this dialy week until switching a nearby dialysis face Patient #14 indicate about this care received.	physician to any changes ed to alter the plan of care for ewed (#17).  250 AM, Employee C, the nursing, indicated not sharing her agencies.  12, start of care (SOC) mosis of benign hypertension, are for the certification period and services of home health dinurse, and podiatrist. The to show coordination of care nurse, the home health aide,  0:15 AM, Employee C ation of care had occurred.  14, SOC 8/12/13 with a disruption, evidenced the g dialysis services along with es. The clinical record failed ation of care with the dialysis	G 17	6	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		157596	B. WING _			C 06/03/2014
	ROVIDER OR SUPPLIER	:		STREET ADDRESS, CITY, STATE, ZIP COD 425 S JOLIET ST STE 312 DYER, IN 46311	E	00/03/2014
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
G 176	Continued From pag		G 1	76		
	in the record between dialysis facility.	n the skilled nurse and				
	care for the certificating 4/19/14 and 4/20/14 for 2/19/14 - 4/19/14 the physician. The shealth aide and skilled record evidenced the visit two times a weed certification periods. 5/29/14 at 12:05 PM, been visiting the pating documentation since administrator was away corrected or docume	s mellitus, included plans of on periods of 2/19/14 - 6/18/14. The plan of care was signed on 5/19/14 by ervices ordered were home of nurse services. This home health aide was to k for 9 weeks for these According to employee A on the home health aide had ent but had not turned in December 2013. The vare but the concern was not need. The record failed to n between the skilled nurse				
	called by phone with R present. Employed was sent to patient # Employee S, HHA, wunder the agency's c that Employee S had but did not give a dat A stated, "Why she n know. There is a physical with the property of the prope	12:05 PM, Employee A was Employee C and Employee e A indicated Employee C 15's home to check if ras still caring for this patient are. Employee A indicated terminated earlier this year, e of termination. Employee ever reported this, I don't ysician order, but she				
	investigation with our indicated that Employ this. Employee A indi made progress in he still needed to make documentation with h	th the patient. This is under consultant." Employee A yee I, RN, is responsible for cated that Employee I had r work with the agency but improvement with her care of the patients.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '			(X3) DATE SURVEY COMPLETED	
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ROVIDER OR SUPPLIER	С		STREET ADDRESS, CITY, STATE, ZIP CO 425 S JOLIET ST STE 312 DYER, IN 46311	•	00/03/2014	
SUMMARY STATEMENT OF DEFICIENCIES  X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
supervise the home charge of supervision was pleased with thin b. On 5/29/14 at indicated Employee months ago and that seen her in the office c. On 5/29/14 at indicated visiting pat weekend. Employee by Employee A to che Employee S, HHA. knowing that the Employee S, HHA. knowing that the Employee S, HHA was to invested in for months from the and she was to invested indicated the patient indicated Employee services.  d. On 5/30/14 at called via telephone Employee C. She in agency and caring for not turning in home In December 2013. She called her two weeks notes. This was the agency. She indicated turned in the notes at trouble.  e. A document "Physician order" with the supervision of the	health aides well and was in n of this aide. The patient is care from the agency.  It 4:30 PM, Employee R S had resigned a couple of it no one from the agency had it or at a visit with patient #15.  It 4:50 PM, Employee C ident #15 over the past is C indicated she was sent in each on the services of Employee C indicated not imployee S had resigned. She ocumentation had been sent in Employee S HHA's visits stigate if Employee S was still for patient #15. Employee C was cognitively aware and S was providing HHA  It 11:55 AM, Employee S was and spoke to writer and indicated still working for the or patient #15. She indicated health aide visit notes since he indicated Employee A is ago telling her to turn in her only patient she saw for the indicated if she was in in clinical record #15 titled the adate of 2/1/14 and no	G	176			
	CORRECTION  ROVIDER OR SUPPLIER  SUMMARY S (EACH DEFICIENT REGULATORY OR SUPERVISE the home charge of supervision was pleased with thin b. On 5/29/14 a indicated Employee months ago and that seen her in the office c. On 5/29/14 a indicated Visiting pat weekend. Employee by Employee A to che Employee S, HHA. knowing that the Employee S, HHA. kno	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 50 supervise the home health aides well and was in charge of supervision of this aide. The patient was pleased with this care from the agency.  b. On 5/29/14 at 4:30 PM, Employee R indicated Employee S had resigned a couple of months ago and that no one from the agency had seen her in the office or at a visit with patient #15.  c. On 5/29/14 at 4:50 PM, Employee C indicated visiting patient #15 over the past weekend. Employee C indicated she was sent in by Employee A to check on the services of Employee S, HHA. Employee C indicated not knowing that the Employee S had resigned. She only knew that no documentation had been sent in for months from the Employee S HHA's visits and she was to investigate if Employee S was still doing personal care for patient #15. Employee C indicated the patient was cognitively aware and indicated Employee S was providing HHA services.  d. On 5/30/14 at 11:55 AM, Employee S was called via telephone and spoke to writer and Employee C. She indicated still working for the agency and caring for patient #15. She indicated not turning in home health aide visit notes since December 2013. She indicated Employee A called her two weeks ago telling her to turn in her notes. This was the only patient she saw for the agency. She indicated she was sorry she had not turned in the notes and asked if she was in	TOWNER OR SUPPLIER  OME HEALTHCARE INC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 50  supervise the home health aides well and was in charge of supervision of this aide. The patient was pleased with this care from the agency.  b. On 5/29/14 at 4:30 PM, Employee R indicated Employee S had resigned a couple of months ago and that no one from the agency had seen her in the office or at a visit with patient #15.  c. On 5/29/14 at 4:50 PM, Employee C indicated visiting patient #15 over the past weekend. Employee C indicated she was sent in by Employee A to check on the services of Employee S, HHA. Employee S had resigned. She only knew that no documentation had been sent in for months from the Employee S HHA's visits and she was to investigate if Employee S was still doing personal care for patient #15. Employee C indicated the patient was cognitively aware and indicated Employee S was providing HHA services.  d. On 5/30/14 at 11:55 AM, Employee S was called via telephone and spoke to writer and Employee C. She indicated still working for the agency and caring for patient #15. She indicated not turning in home health aide visit notes since December 2013. She indicated Employee A called her two weeks ago telling her to turn in her notes. This was the only patient she saw for the agency. She indicated she was sorry she had not turned in the notes and asked if she was in trouble.  e. A document in clinical record #15 titled "Physician order" with a date of 2/1/14 and no physician signature stated, "D/C [discontinue]	ROWIDER OR SUPPLIER  OME HEALTHCARE INC  SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 50  supervise the home health aides well and was in charge of supervision of this aide. The patient was pleased with this care from the agency, b. On 5/29/14 at 4:30 PM, Employee R indicated Employee S had resigned a couple of months ago and that no one from the agency had seen her in the office or at a visit with patient #15.  c. On 5/29/14 at 4:50 PM, Employee C indicated she was sent in by Employee C indicated she was sent in by Employee S, HHA. Employee C indicated not knowing that the Employee S had resigned. She only knew that no documentation had been sent in for months from the Employee S was still doing personal care for patient #15. Employee C indicated the patient was cognitively aware and indicated Employee S was providing HHA services.  d. On 5/30/14 at 11:55 AM, Employee S was called via telephone and spoke to writer and Employee C. She indicated still working for the agency and caring for patient #15. Employee A called her two weeks ago telling her to turn in her notes. This was the only patient she saw for the agency. As the indicated she was sorry she had not turned in the notes and asked if she was in trouble.  e. A document in clinical record #15 titled "Physician order" with a date of 2/1/14 and no physician order" with a date of 2/1/14 and no physician order" with a date of 2/1/14 and no physician order" with a date of 2/1/14 and no physician order" with a date of 2/1/14 and no physician order" with a date of 2/1/14 and no physician order" with a date of 2/1/14 and no physician order" with a date of 2/1/14 and no physician order" with a date of 2/1/14 and no physician order" with a date of 2/1/14 and no physician order" with a date of 2/1/14 and no physician order" with a date of 2/1/14 and no physician order" with a date of 2/1/14 and no physician order with a date of 2/1/14 and no physician order" with a date o	TOTAL PROPERTY OF THE APPROPRIATE AS BUILDING BUTTON NUMBER 157596  1575976  15759776  1575976  1575976  1575976  1575976  1575976  1575976  15759776  1575976  1575976  1575976  1575976  1575976  1575976  15759776  15759776  15759776  15759777  15759777  15759777  15759777  15759777  15759777  15759777  15759777  15759777  15759777  1575977  1575977  1575977  1575977  1575977  1575977  1575977  1575977  1575977  1575977  1575977  1575977  1575977  1575977  1575977  1575977  1575977  1575977  1575	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		157596	B. WING _			C 06/03/2014
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311	•	00/03/2014
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 176	since 12/13." This in Employee A, adminis  F. Three docum home health aide ca 12/18/13, 2/18/14, and 5. Clinical record #16 diagnosis of bronchit coordination of care provided homemake a social work evalual patient had refused. refusal did not discus order was refused ar physician were awar failed to evidence coother agency.  a. On 6/2/14 at licensed practical nuralso seen by a home homemaker services  b. On 6/2/14 at indicated the patient services and there we about this refusal.  6. Clinical record #1 certification period of order, 4/2/14, MSW eval [evaluation]" The signed by Employee of nursing, and not sepatient had a primary services.	acluded the signature of strator.  The plans and were dated on and 4/18/14.  So SOC 10/23/13 and a sis, failed to evidence with an agency which ar services. Also an order for a sis any details about how the and if the social worker or a of the refusal. The record ordination of care with the  10:30 AM, Employee CC, arse, indicated the patient was a health agency that provided	G 1	76		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED  C 06/03/2014	
	157596		B. WING		
	NAME OF PROVIDER OR SUPPLIER  INCARE HOME HEALTHCARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311	1 00/00/2014
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
G 176	alternate administrate valuation was not is coordination had on or the nurse.  b. On 6/3/14 a indicated the patient worker. There was communication to the about this care refuse the social worker.  c. On 5/30/14 and A/24/14 and A/29/14 with a knife health aide, called worker write any notes write a transfer oasi the patient to the enpatient was admitted Clinical record #17, evidence the physic regarding of the fall.  7. Clinical record #2 discharge on 3/25/1	at 4:45 PM, Employee C, the stor indicated the social work in the record and that no care curred with the social worker  at 1:30 PM, Employee A thad refused to see a social no order or other ne doctor or agency nurse sal and need for the patient to er.  at 4 PM, Employee I, indicated patient #17 had did then cut self on arms on Employee E, the home with an update. The nurse did on this incident and did not s. An informal caregiver took in the sale of the patient to end and stayed several days. Start of care 10/2/12, failed to the cian had been notified	G 176	,	
	certification period of payment source wat plan of care indicated skilled nurse visits 1 HHA visits for person 2 times a week for 9 HHA visits documents.	of 2/1/14 - 4/1/14. The solution is listed as Medicare. This sed the patient was to receive 1 - 2 X weekly for 9 weeks and smal care including showers 1 - 2 weeks. There were also need for 3/25/14, 4/3/14, 6/14, 4/18/14, 4/22/14, and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL1 A. BUILDII	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG			ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 176	was an aide care plano tasks for the home no tasks for the home of the home health age not being aware of bound care communication had been discharged as. Clinical record #2 diagnosis of paraples for the certification pland payment source record were HHA visname of patient #21 this plan of care was of 1 time week for 9 week for 9 weeks. Help 1/2/14, 4/4/14, 4/4/14, 4/4/14, 4/2/14, 4/4/14, and on 3/25/14, 4/10/14, 5/14/14, and 5/21/14 to patient #21 were awere from the following 4/16/14, 4/18/14, 4/2 5/2/14.  a. On 6/3/14 at registered nurse, ind the only one of patient home health aide serior the following health aide seriors.	charge of this patient. There in dated on 1/30/14 that had be health aide to complete.  5 AM, patient #21 indicated be was receiving services from ancy. Patient #21 indicated being discharged. There was on that showed the patient	G	176		
	conducting aide supe	ervisiting patient #22 and ervision. There was no re communication in the services.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		157596	B. WING		C 06/03/2014
	ROVIDER OR SUPPLIER  OME HEALTHCARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311	06/03/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
G 176	Continued From page	e 54	G 1	76	
	indicated that she wa with patients #21 and	:05 PM, the administrator s looking into this situation #22. She stated, "We are is. [The patient] has private			
	Patient services" with personnel furnishing a liaison to assure that effectively and supporting the Plan of Care. This formal care conference current Care plans are interaction Interdisciplant be conducted as respond to changes it services, care, or goal	ciplinary care conferences s often as necessary to n the patient's needs, als Ongoing care conducted to evaluate the			
G 202	Services" with no effective registered nurse a. F	Regularly reevaluates the cordinates necessary	G 20	02	
	Based on clinical rec record review, policy determined the agend health aide had comp	not met as evidenced by: ord review, personnel review, and interview, it was by failed to ensure the home eleted a competency nishing services in 1 of 4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		157596	B. WING			06/	03/2014
	ROVIDER OR SUPPLIER			42	TREET ADDRESS, CITY, STATE, ZIP CODE 25 S JOLIET ST STE 312 YER, IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 202	to affect all the patien from employee U (see home health aides we of 4 home health aides potential to affect all t (see G 214), and faile nurse had made a su patient's home at least of 9 records reviewed home health aide and the potential to affect that receive skilled and (See G 229).  The cumulative effect resulted in the agency home health aide care by the Condition of Pahealth aide services.  484.36(b)(1) COMPE IN-SERVICE TRAI  The HHA is responsible individuals who furnis on its behalf meet the requirements of this services.  This STANDARD is repaired in the resulted in the agency health aide had compevaluation prior to fur home health aide files	s reviewed with the potential ts that receive aide services e G 212), failed to ensure ere evaluated annually in 2 e files reviewed with the he patients of the agency ed to ensure the registered pervisory visit to the st every two (2) weeks in 2 ed of patients that received I skilled services creating all of the agency's patients and home health aide services e was provided as required earticipation 484.36 Home  TENCY EVALUATION &  The one health aide services e competency evaluation ection.  The other is evidenced by: file and policy review and failed to ensure the home eleted a competency inshing services in 1 of 4 is reviewed (U) with the he patients that receive aide		212			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		457500		P. WING		С	
NAME OF D	ROVIDER OR SUPPLIER	157596	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	06/	03/2014
	OME HEALTHCARE INC				25 S JOLIET ST STE 312		
					YER, IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 212		e 56 ne Health Aide, date of hire nt contact in 2009, failed to	G	212			
	include a competency completed upon hire.	skills evaluation had been					
	services" with no effe	titled "Home Health Aide ctive date stated, "Only no meet required standards e."					
	3. On 5/29/14 at 12:2 indicated the personn complete.	21 PM, Employee C, RN, el records were not					
G 214	484.36(b)(2)(ii) COMI IN-SERVICE TRAI	PETENCY EVALUATION &	G	214			
		ete a performance review of le no less frequently than					
	Based on personnel agency failed to ensu	not met as evidenced by: file and policy review, the re the home health aide had in 2 of 4 home health aide U).					
	Findings						
	hire 8/10/07 and unkr	e health aide (HHA), date of nown first patient contact, annual evaluation had been 2.					
		, date of hire 4/9/09 and first 9, failed to include an					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION  A BUILDING		(X3) DATE SURVEY COMPLETED	
		720.25			С	
	157596	B. WING		06	/03/2014	
ROVIDER OR SUPPLIER			, , ,	DE		
IOME HEALTHCARE INC	:		425 S JOLIET ST STE 312 DYER, IN 46311			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
annual evaluation sin skills evaluation had large agency policy Evaluations" with no competency based probe conducted for all experiences.	ce 2010 and a competency been completed upon hire.  Ititled "Performance effective date stated, "A erformance evaluation will employees after 1 year of	G 21	14			
484.36(d)(2) SUPER The registered nurse described in paragrapmust make an on-site	(or another professional oh (d)(1) of this section) e visit to the patient's home	G 22	29			
Based on clinical rec the agency failed to e had made a supervis- home at least every t records reviewed of p received home health creating the potential	cord review and interview, ensure the registered nurse ory visit to the patient's wo (2) weeks in 2 of 9 patients (#12 and #15) that in aide and skilled services to affect all of the agency's					
aide (HHA) services I a week for 9 weeks d of 4/21/14 - 6/29/14 a provided 1 - 2 times a record evidenced tha	nad been ordered 1- 2 times uring the certification period and skilled nurse had been a week for 9 weeks. The t no supervisory visits had					
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR INTERPOLATION O	Tonical record review and interview, the agency failed to ensure the patient's home at least every two (2) weeks.  This STANDARD is not met as evidenced by: Based on clinical record review and a services creating the potential to affect all of the agency's patients that receive skilled and home health aide (HHA) services had been ordered 1- 2 times a week for 9 weeks. The record evidenced that no supervisory visit had been provided from 4/21/14 - 6/29/14 and skilled nurse had been provided from 4/21/14 - 5/29/14 by the	ROVIDER OR SUPPLIER  IDME HEALTHCARE INC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 57 annual evaluation since 2010 and a competency skills evaluation had been completed upon hire.  3. The agency policy titled "Performance Evaluations" with no effective date stated, "A competency based performance evaluation will be conducted for all employees after 1 year of employment and at least annually thereafter."  484.36(d)(2) SUPERVISION  The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.  This STANDARD is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure the registered nurse had made a supervisory visit to the patient's home at least every two (2) weeks in 2 of 9 records reviewed of patients (#12 and #15) that received home health aide and skilled services creating the potential to affect all of the agency's patients that receive skilled and home health aide (HHA) services had been ordered 1-2 times a week for 9 weeks during the certification period of 4/21/14 - 6/29/14 and skilled nurse had been provided 1 - 2 times a week for 9 weeks. The record evidenced that no supervisory visits had been provided from 4/21/14 - 5/29/14 by the	TOMBE HEALTHCARE INC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 57  annual evaluation since 2010 and a competency skills evaluation had been completed upon hire.  3. The agency policy titled "Performance Evaluations" with no effective date stated, "A competency based performance evaluation will be conducted for all employees after 1 year of employment and at least annually thereafter."  484.36(d)(2) SUPERVISION  The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.  This STANDARD is not met as evidenced by:  Based on clinical record review and interview, the agency failed to ensure the registered nurse had made a supervisory visit to the patient's home at least every two (2) weeks in 2 of 9 records reviewed of patients (#12 and #15) that received home health aide and skilled services creating the potential to affect all of the agency's patients that receive skilled and home health aide services.  Findings  1. Clinical record #12 evidenced home health aide (HHA) services had been ordered 1- 2 times a week for 9 weeks fulled normen health aide entropy of 4/12/14 - 6/29/14 and skilled ourse had been provided from 4/21/14 - 5/29/14 by the	TOME HEALTHCARE INC  157596  1	

PRINTED: 06/24/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		457500	D WING	P. WING		С	
		157596	B. WING			06/	03/2014
	ROVIDER OR SUPPLIER  OME HEALTHCARE INC	:		4	TREET ADDRESS, CITY, STATE, ZIP CODE  25 S JOLIET ST STE 312  DYER, IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 229	Continued From page	e 58	G	229			
	On 5/29/14 at 10 Registered Nurse, incomotes were missing for 2. Clinical record #15 a diagnosis of diabeted care for the certification 2-18-14 (HHA to visit skilled nurse 1 - 2 time 4/19/14 (HHA 2 times week, and 4/20/14 - 6 week). The plan of compassion was signed on 5/19/1 home health aide had not turned in doc 2013. The administration concern was not corresponded to the corresponded with the cord. The registered these visits during this a. On 5/29/14 at administrator, was called that Employee C and Employee	dicated the supervisory om the record.  Start Of Care 8/23/13 and es mellitus, included plans of on periods of 12-21-13 - 1 - 2 times a week and es a week), 2/19/14 - s a week and SN 1 times a so/18/14 (SN one times a are for 2/19/14 - 4/19/14 4 by the physician. The dispension between the physician and the ected or documented. Its had been made since no documentation in the ed nurse had not supervised is time.					
	care. Employee A ind terminated earlier this date of termination. It she never reported the physician order, but so the patient. This is un consultant." Employee I, Registered Nurse, i Employee A indicated	ient under the agency's dicated that Employee S had s year, but did not give a Employee A stated, "Why iis, I don't know. There is a the maintains contact with ender investigation with our ee A indicated that Employee s responsible for this. I that Employee I has made with the agency but still					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		157596	B. WING _		C 06/03/2014		
	ROVIDER OR SUPPLIER	С	,	STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311			
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 229	with her care of the indicated that Employements and reservices from Incare indicated that she weekend. Patient # services from Incare indicated that she weekend. Patient # services from Incare indicated that she weekend. Patient # services from Incare indicated that she weekend. Patient # services from Incare indicated that she weekend that she we weekend that she we were well as the weekend that she we we were well as the weekend that she we were well as the weekend that she we were well as the weekend that she we were well as the well as the weekend that she we were well as the weekend that w	t 4:30 PM, Employee R S had resigned a couple of t no one from the agency had e or at a visit with patient #15.  t 4:50 PM, Employee C tient #15 over the past 15 was happy with the e and the aide. Employee C as sent in by Employee A to es of an Employee S, HHA. ed not knowing that Employee	G 2	229			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
					С		
		157596	B. WING			06/	03/2014
NAME OF PR	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
INCARE HOME HEALTHCARE INC					125 S JOLIET ST STE 312		
				DYER, IN 46311			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 229	Continued From page trouble.	<del>2</del> 60	G:	229			
G 330	titled "Physician order no physician signatur HHA - pt [patient] has since 12/13 " This inc Employee A, administ	ument in clinical record #15 " with a date of 2/1/14 and e stated, "D/C [discontinue] private duty assistance luded the signature of trator. NSIVE ASSESSMENT OF	G:	330			
	Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary  This CONDITION is not met as evidenced by: Based on clinical record and document review and interview, it was determined the agency failed to maintain compliance with this condition to ensure the registered nurse completed a review						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
						С	
		157596	B. WING			06/	03/2014
NAME OF PROVIDER OR SUPPLIER  INCARE HOME HEALTHCARE INC			42	TREET ADDRESS, CITY, STATE, ZIP CODE 25 S JOLIET ST STE 312 YER, IN 46311			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
of all 12 rd of ca common home more potential hosp assed discorecco (see The results common 484. G 337 484. The reviews usin effect drug drug none form was the acommon was 14, accommon form was 14, accommon form the form was 14, accommon form was 14, accommon form the form was 14, accommon form was 14, acco	ecords reviewed (are comprehensive pleted within 48 has from a hospital e in 1 of 12 recordential to affect all tipitalized (see G 3 essment had been charge or transfer ords reviewed with e G 341).  Cumulative effect all the pitalized in the agency planace with the C in the agency planace with the C in the agency of all medications and drug reacting in order to identicate and drug reacting interactions, dup compliance with design interactions, dup compliance with design interactions and pleted a review of a taking for 4 of 12 and 15).  Sclinical record #7,	patient was taking for 4 of See G 337), a resumption e assessment had been ours of the patient's return admission of 24 hours or ds reviewed creating the he patients who were 40), and the comprehensive hupdated at the time of from the agency in 3 of 4 transfers or discharges  of these systemic problems to being found out of condition of Participation to Assessment of Patients. BIMEN REVIEW  ssessment must include a const the patient is currently lifty any potential adverse cons, including ineffective ant side effects, significant licate drug therapy, and		3337			

				(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
(X4) ID PREFIX		157596	B. WING		C 06/03/2014		
(X4) ID PREFIX		137330	5: ******			06/	03/2014
(X4) ID PREFIX	/IDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID PREFIX	INCARE HOME HEALTHCARE INC			4	25 S JOLIET ST STE 312		
PREFIX	IL HEALIHOAKE IIIO			D	OYER, IN 46311		
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
in (pp th gi gl m ro pr Ri pr 2. di pr ev pa ro in do th 3. of 2/ha th ev 4.	ontinued From page cluded a medication prior to the start of care reasons for as need even including antibidity of an analysis of the start of care for every medication profile lister outes for every medication profile.  On 5/30/14 at 2:5 registered Nurse (RN rofile was in error.  Clinical record #13 registered a complete reviewed on 5/3 reduced a complete restch was listed withoute of administration on 5/30/14 at 2:2 dicated the medicationse, frequency, and referent error the certificationse, frequency, and referent error the certification of 5/30/14 at 9:5 reduced occurred since 10 on 5/30/14 at 9:5 reduced error for the certification of 5/30/14 at 9:5 reduced error for days.  Clinical record #15, reduced error for the certification of the certification	profile reviewed on 5/21/13 pr	G	337			
I	e medication profile						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		157596	B. WING	B. WING		C 06/03/2014	
NAME OF PROVIDER OR SUPPLIER  INCARE HOME HEALTHCARE INC			4	TREET ADDRESS, CITY, STATE, ZIP CODE 25 S JOLIET ST STE 312 DYER, IN 46311	1 00/	03/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 337	484.55(d)(2) UPDATE COMPREHENSIVE A  The comprehensive a updated and revised of the OASIS) within A return to the home from 24 hours or more for a diagnostic tests.  This STANDARD is represented and interview, the agree comprehensive assess within 48 hours of the a hospital admission of 12 records reviewed affect all the patients (patient #14).  The findings include  1. Clinical record #14 to evidence a resumple assessment had been of the patient's dischart reatment of a failing grant and dated 20 had been hospitalized a failing permacath.	e had not been reviewed. E OF THE ASSESSMENT  assessment must be (including the administration 48 hours of the patient's om a hospital admission of any reason other than  not met as evidenced by: ord and document review ency failed to ensure a asment had been completed a patient's return home from of 24 hours or more in 1 of creating the potential to who were hospitalized  4, start of care 8/12/13, failed ation of care comprehensive in completed within 48 hours arge from the hospital for permacath.  Community Healthcare (21/14 evidenced the patient d from 2/21/14 - 2/23/14 for		337	DEFICIENCY)		
	the patient had been on 2/23/14 and had n	PM, Employee C indicated discharged from the hospital ot had a resumption of care asment completed within the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	` ′	(X3) DATE SURVEY COMPLETED			
		157596	B. WING _			C 06/03/2014		
NAME OF PROVIDER OR SUPPLIER  INCARE HOME HEALTHCARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311		00/03/2014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
G 340	Continued From page	e 64	G 3	40				
G 341	required time frame. 484.55(d)(3) UPDAT COMPREHENSIVE		G 3	41				
	of the OASIS) at disc This STANDARD is Based on clinical rec	(including the administration sharge.  not met as evidenced by: cord and document review						
	comprehensive assethe time of discharge	ency failed to ensure the ssment had been updated at or transfer from the agency I, #16, #17) reviewed with es noted.						
	The findings include							
	services had been pr for 9 weeks during the 12/10/13 - 2/7/14 and 2/18/14 and 3/7/14. It transferred to the hose returned home on 2/2 discharge assessment the patient had been oasis start of care as the RN on 2/26/14. To closed record in a file but failed to show that	23/14. Neither a transfer or nt had occurred to show that discharged. However, an sessment was completed by the record was kept as a e cabinet for closed records, at any discharge assessment turred. It was not known that						
	System" and dated 2	itled "Community Healthcare /21/14 evidenced the patient d from 2/21/14 - 2/23/14 for						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED			
		157596	B. WING			C <b>06/03/2014</b>		
	NAME OF PROVIDER OR SUPPLIER  INCARE HOME HEALTHCARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311		06/03/2014		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
G 341	Continued From pag	ge 65	G 34	1				
	that services stoppe been notified of this	at 7 PM, patient #14 indicated d and that he / she had not change in the plan of care.						
	indicated the patient the services of the a discharge assessme The patient had bee	at 2:26 PM, Employee C thad been discharged from gency and there was no ent or discharge summary. In transferred to the hospital rned home on 2/23/14.						
	certification period o evidence a transfer been completed by t	7, start of care 2/2/14 with a of 4/3/14 - 6/1/14, failed to or discharge assessment had the skilled nurse after the nsferred to the hospital on						
	Registered Nurse, ir transferred to the ho discharged from the	t 4:30 PM, Employee I, adicated the patient had been espital on 4/29/14 and was hospital on 5/5/14. No e assessment or summary d at that time.						
	indicated the patient	11:42 AM, Employee A had been discharged and ted living in Michigan City.						
	neoplasm, included certification period o payment source was plan of care indicate skilled nurse visits 1 and home health aid	1, SOC 10/3/13 and 4 and diagnosis of brain a plan of care for the f 2/1/14 - 4/1/14. The s listed as Medicare. This d the patient was to receive - 2 times weekly for 9 weeks de (HHA) visits for personal ers 1 - 2 times a week for 9						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION  S		(X3) DATE SURVEY COMPLETED		
		157596	B. WING			C 06/03/2014	
NAME OF PROVIDER OR SUPPLIER  INCARE HOME HEALTHCARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312  DYER, IN 46311		06/03/2014		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
G 341	for 3/25/14, 4/3/14, 4/18/14, 4/22/14, an of this patient. There on 1/30/14 that had aide to complete.  On 6/3/14 at 7:4 not knowing he / sh the home health age not being aware of b	also HHA visits documented 4/9/14, 4/11/14, 4/16/14, d 4/24/14 after the discharge was an aide care plan dated no tasks for the home health 45 AM, patient #21 indicated e was receiving services from ency. Patient #21 indicated being discharged. There was not showed the patient had	G 34	.1			